CONFIDENTIAL PEDIATRIC HEALTH RECORD

Current Health Condition:

What are your goals for this visit?
____
____
____
____

Prioritize your most important health concerns today:

	Concern	Onset	Frequency	Severity
	Ex. Ear infections	Nov. 2000	1x/month	mild/mod/severe
1.	____________	________	______	__________
2.	____________	________	______	__________
3.	____________	________	______	__________
4.	____________	________	______	__________
5.	____________	________	______	__________

What, if any, treatments have you tried?
____
____

Are you currently being treated by a physician? Yes/No (*circle*)
Physician name: ____________________ Condition:______________________________

What prior experiences have you had with alternative or complementary medicine?
____
____

Past Medical History:

Duration of pregnancy: ______________________ Birth Weight: ________________
Any complications during pregnancy? ______________________________________
Any drugs taken during pregnancy? (include over-the-counter medications): _______________
____
Any alcohol? ____________ How much? ______________________________
Any tobacco? ____________ How much? ______________________________
High blood pressure during pregnancy? _____________________________________
Illnesses/infections during pregnancy? _____________________________________

Labor and Delivery:

How long was labor? ____
Breech or unusual presentation? ____
Cesarean birth? ______________________ Reason: ________________________
Pain medication used? ____
Pitocin used? __________________________ Forceps used? __________________

Delay in respiration or cry? ___________________________ Apgar Score, if known? ____________________
Was oxygen administration necessary? ____
Type of anesthesia employed for mother? ____

Newborn:
Jaundice? ____________________________________ Cyanosis? ______________________________________
Infection? ____________________________________ Seizures? ______________________________________
Anemia? ____
Other important conditions? ____
Breast fed? If so, for how long? ____

Development: (Write age beside development)

1. Smile		8. Crawled	
2. Laughed out loud		9. Pulled to stand	
3. First words		10. Walked around furniture	
4. First put words together: i.e. bye-bye		11. Walked unassisted	
5. Completed sentences		12. Rode bicycle	
6. Rolled over		13. Tied shoelaces	
7. Sat without support		14. Toilet trained	

Illnesses:
1. Hospitalizations:
   a. Age _______________________ Reason ____
   b. Age _______________________ Reason ____
2. Any history of head injury? ____
3. Has this child ever been unconscious? ____

Seizure History:
Has your child ever had a convulsion?
1. With fever? ___________________________________ Ages: ____
2. Without fever? ________________________________ Ages: ____

Medications and Allergies:

Current **medications** (include prescription and over-the-counter drugs):

Medication	Reason	When Started	Dosage Per Day

Current **vitamins/minerals/herbal supplements, etc**:

Supplement + Brand	**Reason**	**When Started**	**Dosage Per Day**

Allergies to medicines or substances:
____
____
Please describe reaction: ____
____

Family History:

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers/Sisters				

Check if *blood* relatives had any of the following:

Check	Disease	Relationship	Check	Disease	Relationship
	Mental retardation			Headaches	
	Migraines			Hay Fever	
	Movement disorders			Heart Disease	
	Asthma, Allergies, Hives			High Blood Pressure	
	Autoimmune Disease			HIV/AIDS	
	Cancer			Kidney Disease	
	Paralysis			Mental Illness	
	Depression			Paralysis	
	Diabetes			Obesity	
	Epilepsy			Parkinson’s Disease	
	Gastrointestinal Disease			Suicide	
	Cerebral palsy			Tuberculosis	

School Assessment: (According to parents)
Grade level: _______________________ Reading level: _______________________________________
Motivation: __________________________ Behavior: ____
Attention: ___________________________ Achievement: ____________________________________
Relationship with teachers and peers: ____
Eyesight: ___________________________________ Hearing: _____________________________________
Motor coordination: ______________________________ Speech: ________________________________
Other health problems: ____

Health Habits:

What physical activity does your child participate in, and how often?
____

Energy level? ____

Describe child's sleep pattern (i.e.hours/night, wake rested):
____
____

Nutrition:

How many meals does your child generally eat per day? ______ Does he/she skip meals? _______________
Please describe an average breakfast: ____
Average lunch: ____
Average dinner: ____
Snacks: ____
What are your child's sources of protein? ____
What and how much does your child drink on a typical day (i.e. water, soda, caffeinated drinks, juice)?
____

Is your child currently on a special diet? Food allergies? Foods avoided? Vegetarian? Please explain.
____
____

How often do you eat out? ____
Who prepares the meals at home? ____

Other:

Previous complications of any therapy? ____
____
Has your child received the standard vaccination schedule? _______________________________
Any additional vaccines? ____

Questions that you want answered during this examination: ______________________________
____
____

Any additional information? ____
____
____

Signature:

I certify that the above information is correct to the best of my knowledge. I will not hold
Dr. Hudson or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ___________________________ Relationship to child _____________________
Date ______________________